CLARIFICATION OF TERMS USED IN LONG TERM CARE ENFORCEMENT

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Michigan Department of Consumer and Industry Services

Serving Michigan…Serving You

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Index

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I. Introduction

Act No. 171 of the Public Acts of 2000 requires the Michigan Department of Consumer and Industry Services to clarify several terms as applied to the nursing home oversight program for the purpose of providing more consistent regulation of nursing homes in Michigan. The terms specified in the Act are:

- Harm
- Potential harm
- Avoidable
- Unavoidable
- Immediate jeopardy

As specified in the Act, the Department consulted with a workgroup including nursing home provider groups, the American Medical Directors Association (AMDA), the Department of Community Health, the State Long Term Care Ombudsman, and the federal Health Care Financing Administration (HCFA). A list of the Workgroup members is set forth in Attachment A.

The Workgroup met four times in Lansing to discuss the terms and a process to clarify how the terms can be consistently applied in the survey process**.** In addition, the Workgroup discussed how these clarifications could promote the delivery of quality care for residents by providing guidance to providers and recognizing it in the survey process. The Department wishes to thank each of the participating organizations for their participation in this process, and to extend special thanks to Dr. Steven Levenson of the American Medical Directors Association for his invaluable assistance in guiding the Workgroup in its deliberations.

II. Federal Definitions, Standards, Survey Procedures and Guidance to Surveyors

The federal government requires each provider to meet minimum standards for care and authorizes states to conduct onsite surveys to ensure provider compliance with those requirements. Congress passed the enabling legislation for the current survey process in 1987, as part of the Omnibus Budget Reconciliation Act (OBRA). The Health Care Financing Administration (HCFA) promulgated care and operating standards and these requirements are reflected in TAG numbers. State survey agencies use the TAG numbers to cite deficiencies (i.e., failures to comply with requirements).

To promote national uniformity, HCFA has published the Guidance to Surveyors to assist surveyors and facilities in interpreting specific TAGS and has published a State Operations Manual (SOM) that establishes uniform procedures for conducting surveys. The SOM includes instructions about how to gather and interpret information collected before and during the survey, how to draft and present the statement of deficiencies to facilities, how to draw conclusions about the scope and severity of the facility's alleged non-compliance, how to determine penalties for noncompliance, and other miscellaneous issues such as various levels of appeal. The SOM is used by all state agencies to conduct the survey, using identified

procedures and tasks. The SOM and the Guidance to Surveyors in Appendices P and PP also provide guidance on determining whether a facility's failure to meet a requirement is related to a resident's overall condition and status (actual or potential negative outcomes) and guidance for determining the scope and severity of noncompliance with requirements.

III. Importance of the Terms in the OBRA Survey and Enforcement Processes

Scattered throughout the State Operations Manual are various instructions about the methods and criteria to be used in determining compliance and characterizing deficiencies. The basic methodology includes the following steps:

- Reviewing previous results of facility performance and resident outcomes;
- Reviewing indicators of current resident status;
- Selecting a case mix stratified sample of residents based on quality indicators and other on and off site information;
- Making observations (including medication pass, kitchen and environment); reviewing relevant medical and psychological record information; and reviewing facility policies, procedures and staffing;
- Asking questions, talking to various individuals and gathering additional information;
- Comparing information about a facility's performance to the requirements;
- Drawing conclusions about the facility's overall compliance and about compliance with specific requirements;
- Determining whether the facility's non-compliance had a detrimental impact on a resident's condition or status, including actual or potential negative outcomes;
- Determining the scope and severity of noncompliance with requirements.

Negative outcomes that are the "unavoidable" consequences of the resident's condition are not intended to result in citations. A determination of non-compliance, therefore, depends both on a finding of a "negative outcome" or potential for a negative outcome and a determination that the outcome is linked to a deficient facility practice (i.e. the outcome was "avoidable" as opposed to "unavoidable"). When a deficient facility practice has been found, the avoidable negative outcome (i.e., the violation) must be characterized in terms of three levels of scope and four levels of severity. Table 1 sets forth the levels of scope and severity used to characterize avoidable outcomes.

Immediate Jeopardy To Resident Health Or Safety	J	K	L

Actual Harm That Is Not Immediate Jeopardy	G	H	I
No Actual Harm With *Potential* For More Than Minimal *Harm* That Is Not Immediate Jeopardy	D	E	F
No Actual Harm With Potential For Minimal Harm	A	B	C
	Isolated	Pattern	Widespread

Table 1-- OBRA Scope and Severity Table For Avoidable Negative Outcomes

Despite the abundance of instructions and procedures, providers and survey agencies still disagree on the application of the definitions of "avoidable," "unavoidable," "harm," "potential harm" and "immediate jeopardy" in specific cases involving citations. These disputes are significant because how the terms are applied will determine whether there has been a violation at all, and if there has been a violation, the proper positioning of the violation on the scope and severity grid. As a practical matter this is critical to consistency in both the survey and enforcement systems because, under the OBRA sanctions, the position of a single citation on the scope and severity grid may determine the severity of a sanction and may even determine whether a facility is terminated from participation in the Medicare/Medicaid Program or not. Without a common understanding and consistent application of these terms, there will continue to be disagreement over whether essential care issues are uniformly addressed in the survey process or whether providers with similar care patterns are treated consistently.

The importance of properly assigning scope and severity has been recognized nationally. The newly released Institute of Medicine (IOM) report entitled, Improving the Quality of Long-term Care (National Academy Press, 2001), concludes, " . . . States vary substantially in their survey and enforcement findings, and no evidence suggests that this variation is a function of corresponding variation in the quality of care provided in the states." (p.151) HCFA has also instituted a review for the purpose of developing further guidance for improving the consistency of scope and severity interpretations nation-wide.

IV. Professional Clinical Practice Guidelines

In addition to the standards and guidelines issued under OBRA, professional organizations interested in long-term care, such as the American Medical Directors Association (AMDA), the American Nurses Association (ANA) and the American Dietetic Association (ADA) among others, have developed clinical practice guidelines for nursing home care. These practice guidelines reflect accepted processes for identifying and managing specific medical conditions found in the nursing home population. See Appendix B.

The processes set forth in the AMDA Guidelines, for example, are based on the input of nationally representative workgroups and were reviewed carefully by experts in the fields of geriatrics and gerontology. (See Appendix B for a listing of AMDA Guidelines.) For the areas they address, the guidelines translate accepted recommendations for medical and nursing care into specific procedures for nursing homes--focusing on critical nursing home tasks in ways that are often not covered, or are only partially covered, in OBRA regulations.

V. Relating Clinical Practice Guidelines to Definitions and Standards

The possibility of considering professionally accepted clinical practice guidelines as a means of evaluating and improving care when regulatory requirements are not specific is recognized in the Institute of Medicine report which states, "Although basic standards for long-term care are often defined and enforced primarily through the legislative and administrative process, standards put forth from other nongovernmental sources are also important." (p. 137)

Although they address similar issues in a slightly different way, clinical practice guidelines do not appear to be inconsistent with the OBRA standards and guidelines. In fact, when they apply to an area of care not specifically addressed by OBRA, accepted clinical practice guidelines offer a consistent framework for understanding and evaluating nursing home practice. The OBRA regulations also recognize that accepted standards of clinical practice may be considered in evaluating the level of care provided to residents. (42 CFR 483.20(k)(3)(i) pertaining to F281) Equally important, the Workgroup recognized that the dissemination of accepted clinical practice guidelines may provide a basis to help facilities understand resident needs and care requirements, develop approaches to meet those needs, and hopefully will result in fewer deficiencies being cited in a survey.

The remaining parts of this report discuss how the recognition of accepted clinical practice guidelines can help clarify the application of "avoidable," "unavoidable," "harm," "potential harm" and "immediate jeopardy" in specific cases. The last part of this report sets forth a process for implementation of this concept.

VI. Consideration of Clinical Practice Guidelines in Applying "Avoidable" and "Unavoidable"

A fundamental purpose of the survey process is to identify actual or potential negative outcomes that may have resulted from improper or deficient practices incompatible with OBRA standards. The SOM and Guidance to Surveyors speak about "negative outcomes" and include some examples, but do not always define the term. A negative outcome may include a decline in condition or function, failure to improve or to achieve highest practicable outcome, or other outcome which impacts a resident negatively.

Facilities have the obligation to identify situations that place a resident at high risk for negative outcome and to develop specific interventions to try to prevent the negative outcome. It is clear, however, that many aspects of function and quality of life of the frail elderly are profoundly influenced by various physical problems and medical conditions that result in negative outcomes that may not be attributable to deficient practice. OBRA accepts that not every negative outcome is the fault of a deficient facility practice, and that an "unavoidable" negative outcome should not result in a citation. The Guidance to Surveyors and investigative protocols refer repeatedly to "medically unavoidable" negative outcomes as situations where a negative outcome can be explained by underlying medical conditions or related physical or other factors.

In some instances, the Guidance to Surveyors lists examples of situations or conditions that might make a negative outcome avoidable or unavoidable, and they list some areas (assessment, care planning, etc.) that must be done adequately. Where the SOM or Guidance to Surveyors are specific, they must be followed. For example, Appendix P of the SOM

provides that some requirements need to be met for each resident. These requirements may, in fact, be predicated upon a process involving sequential steps that must occur consistently to successfully meet the requirement. Any violation of these requirements, even for one resident, is a deficiency. These resident specific requirements in the SOM will be relevant to the concept of avoidable/unavoidable.

"Avoidable" implies that a negative outcome could have or should have been different than it was. This, in turn, depends on clearly identifying the facility's responsibility to have done something more, different, better, or sooner than what it did to prevent the situation from occurring--or on clearly identifying the facility responsibility to detect and manage the problem once it occurred. Conversely, a negative outcome may be medically "unavoidable" if it is the result of a resident's underlying condition, problem, or risk, and did not occur because of a deficient practice**.** Many situations in the Guidance to Surveyors and Investigative Protocols offer guidance based on regulatory requirements about processes (adequate assessment, timely intervention, relevant care plan, etc.) but do not provide enough detail about those processes to assist in the determination and documentation of "avoidable" in a specific case.

To improve consistency and avoid disputes over "avoidable" and "unavoidable," both providers and surveyors must have a common understanding of the circumstances where it can reasonably be said that certain actions or inactions will lead to "avoidable" negative outcomes. In other words, some shared concept of accepted practice. The SOM states, "Certain facility systems requirements must be met in an absolute sense (e.g., a facility must have a RN on duty seven days a week, unless it has received a waiver). Other facility system requirements are best evaluated comprehensively, rather than in terms of a single incident." (P-66 to P-67) It is those situations when the "facility system requirements must be viewed comprehensively" -- and neither the SOM nor Guidance to Surveyors are specific as to process expectations--that there has been confusion and inconsistency both in the survey process and in actual facility practice.

Any process composed of sequential steps must occur consistently to successfully accomplish an objective. For example, adequately evaluating resident weight loss requires a process of weighing the resident correctly, recording the weight, telling someone if the weight loss is outside of expected parameters, etc. Accepted "process indicators" identify important steps and anything that must or should be done at each step. If accepted process indicators have been recognized in areas where the SOM and Guidance to Surveyors are not specific, they can provide a framework so that facilities know what should be done.

Even where the Guidance to Surveyors is detailed, accepted practice guidelines may assist in determining if a facility has performed its duties. For example, in geriatric care, it may not be universally indicated or helpful to order all possible diagnostic tests, or to offer or render all possible treatment options. The appearance of various options in the Guidance to Surveyors (for example, option to get laboratory tests for someone at risk for weight loss) does not imply that the option must always be followed. Reference to accepted clinical practice guidelines could provide uniform guidance as to what should be done in specific cases.

Overall documentation of compliance with accepted process indicators is relevant information in considering whether a negative outcome was "unavoidable" and may be considered in the application of that term. While it is desirable that procedures always be done consistently, variations in processes do not preclude evidence of substantial compliance with accepted processes. For example, evidence of substantial adherence to accepted practice might include: 1) a valid procedure that is detailed enough to include all appropriate steps; 2) evidence that the facility monitors the procedure and adequately educates staff responsible for performing

essential steps; 3) evidence that the facility has a means to ensure that processes occur correctly and consistently, 4) evidence that the facility takes action if it discovers that procedures are not being followed adequately; and 5) evidence that the facility reviews its processes and procedures when negative outcomes occur and makes appropriate changes in its processes and practices to try to prevent recurrence of the negative outcome.

VII. Consideration of Clinical Practice Guidelines in Applying "Actual Harm"

Level 3 on the Scope and Severity Grid is defined as "Actual Harm That Is Not Immediate Jeopardy." The SOM guidance on severity levels (P-71 to P-72) defines Level 3 as follows:

> "Level 3 is noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could or has caused limited consequence to the resident."

In accordance with these definitions and guidelines, a determination of "Actual Harm" (Severity Level 3) is based on all of the following:

- Identification of physical, functional, or psychosocial damage or deterioration (negative outcome) that has more than a "limited consequence" for the specific resident which is attributable to a deficient facility practice.

- An indication of how the negative outcome compromises the resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care and provision of services.

In some cases, the SOM and Guidance to Surveyors clearly provide that a certain negative outcome is considered actual harm. In such cases, the OBRA requirements must be followed. In addition to the primary consideration of the impact on the specific resident, facility documentation of adherence to accepted clinical practice guidelines may help in determining whether a negative outcome constitutes "actual harm" as described above.

First, in determining whether a negative outcome was of "limited consequence" the survey agency must consider whether most people in similar circumstances would feel that the damage was of such short duration or impact as to be inconsequential or trivial. When the SOM or Guidance to Surveyors are not specific, the consequence of a negative outcome may be considered more limited if it occurs in the context of overall procedural consistency with accepted clinical practice guidelines--as compared to a substantial inconsistency with or variance from with those guidelines.

Second, in determining whether a negative outcome was avoidable or unavoidable the survey agency can be greatly assisted by reference to accepted clinical practice guidelines as discussed above. The existence of a negative outcome, by itself, is not sufficient to conclude that there is a violation.

Third, in determining whether the negative outcome compromises the resident's ability to

maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being, the survey agency must make some assumptions as to what could reasonably have been expected--given the resident's comprehensive assessment, plan of care, and provision of services. When the SOM or Guidance to Surveyors are not specific, consideration of the degree of a facility's adherence to accepted clinical practice guidelines and impact of the deficient facility practice on the resident will help provide consistency in considering the degree of compromise and future risk to the resident's ability. The risk of significant compromise to the resident is reasonably greater in the context of substantial deviation from such guidelines than in the case of overall adherence.

VIII. Consideration of Clinical Practice Guidelines in Applying "Potential Harm"

A potential negative outcome is one that did not happen, but might or could have happened. The federal scope and severity grid refers to "potential" and "harm" when it describes Level 2 Severity as " No Actual Harm With Potential For More Than Minimal Harm That Is Not Immediate Jeopardy". The SOM further states:

> "Level 2 is noncompliance that results in no more than minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential (not yet realized)." (P-71 to P-72)

"Potential for more than minimal harm" implies something that has not resulted in a Level 3 outcome but could or would have. It also implies that the negative outcome would have compromised a resident's ability to reach and/or maintain his or her highest practicable physical, functional, and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

SOM Appendix P (P-66 to P-67) provides that the lack of reaching the highest practicable level of well-being does not require a determination that deterioration or damage has occurred and thus that the damage impair the resident's ability to maintain or reach the highest practicable level of well being.

As with the other definitions, reference to accepted clinical practice guidelines could provide the needed framework when the federal SOM and Guidance to Surveyors are not clear. It is reasonable to conclude that the potential "to compromise the resident's ability to maintain and/or reach his/her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services" will be greater in the context of substantial deviation from generally accepted clinical practice guidelines than in the case of substantial adherence. It is certainly reasonable to conclude that if a facility adheres to accepted clinical practice guidelines compatible with the SOM and bases care upon identified resident need with consistent ongoing intervention and re-evaluation, a facility is more likely to have positive outcomes and/or medically unavoidable negative outcomes.

IX. Consideration of Clinical Practice Guidelines in Applying "Immediate Jeopardy"

Immediate Jeopardy is defined in the SOM and regulations as:

> "A situation in which immediate corrective action is necessary because the

> facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility." (See Appendix Q.)" (P-71 to P-72)

Appendix Q of the SOM offers numerous examples of situations that could constitute Immediate Jeopardy. But general, consistent criteria for determining whether a specific deficient practice or negative outcome presents an immediate risk or requires an immediate correction are less clearly explained.

The definition refers to a "situation" for which immediate intervention is needed to prevent future or repetitious serious injury, harm, impairment or death. The trigger may be actual harm that has already occurred, but the concern is with potential serious negative outcomes in the future--over a potential serious negative outcome to residents requiring immediate intervention before routine regulatory process can be applied. The objective is to protect residents from serious harm.

The Guidance to Surveyors and Appendix Q list specific examples of Immediate Jeopardy and situations that must be interpreted as Immediate Jeopardy. Where OBRA policy with respect to a specific situation is clear, it must be followed. In other cases, the determination of Immediate Jeopardy will be more consistent and persuasive if it is triggered by a situation in which concern for the well being of other residents is generally considered to be reasonable.

For example, in some cases, such as certain fire or environmental issues, the reasonableness of the concern is evident. In other cases, however, where there is no clear guidance from the SOM or Appendix Q, reference to generally accepted practice guidelines could provide a consistent framework for this determination. When the situation involves avoidable harm or potential harm (as discussed above), the degree of danger to other residents is reasonably higher if there is evidence of a flagrant failure by the facility to comply with accepted practice than if the facility has substantially and continuously complied with generally accepted guidelines or practices.

Where federal guidance is not clear and accepted process guidelines have been recognized, a process failure giving rise to an Immediate Jeopardy might involve an egregious, widespread or repeated process failure, and the absence of reasonable efforts to detect and prevent it. Considerations might include whether the facility:

- Could reasonably have been expected to know about the deficient practice(s) and stop it (them) from happening, but did not;
- Could or should have been expected to identify the deficient practice and correct it after it happened, but did not;
- Could or should have been able to anticipate that a negative outcome (i.e., serious injury, serious harm, impairment or death) might result from continuing the practice, but did not;
- Could or should have known that a widely accepted high risk practice is or could be problematic, but did not;
- Could or should have been expected to detect the process problem in a more timely fashion, once it occurred, but did not.

Any of these factors, and especially several of these factors concurrently, might lead to a conclusion that the situation is one in which the facility's practice makes future adverse events likely to occur if immediate intervention is not undertaken, i.e., "Immediate Jeopardy."

Conversely, if these tests are not met, the situation may involve harm or potential harm that is not Immediate Jeopardy.

X. Conclusions

Both the state survey agency and nursing home providers can benefit from more specific guidance to identify appropriate practice related to various aspects of care covered by OBRA. Mutually accepted, evidence based clinical guidelines and process indicators are a means to that end, and can provide a needed framework for consistent application of the definitions of "avoidable," "unavoidable," "harm," "potential harm" and "immediate jeopardy" in cases where federal guidance is not clear.

While the primary responsibility of the surveyor is to survey for compliance with federal requirements using federal forms and procedures, accepted process-oriented guidelines and protocols can also be used to provide both providers and surveyors with a common recognition of appropriate processes. These clinical practice guidelines would not have the binding effect of administrative rules or guidelines as defined by the Michigan Administrative Procedures Act and would not impact the duties of either the state or providers under state or federal law. They would, however, serve as a framework for improved communication and consistent application of key terms used in the survey and enforcement process for the care areas they address.

To accomplish this there must be:

- A process for identifying specific clinical practice guidelines which might be considered in the survey process, based upon their mutual acceptance by both providers and the survey agency;
- Tools, such as assessment forms, which relate the guidelines to factors for assessing compliance;

- A mechanism to disseminate the guidelines and factor tools to both providers and surveyors so that expected practices and processes are well known and consistently applied; and
- Training for both surveyors and providers to foster a common understanding and consistent application.

To be effective, the process-oriented guidelines and protocols used for this purpose must be:

- Accepted by nationally recognized experts (i.e., technically sound and reflecting good geriatric care);
- Accepted as appropriate by both providers and the state;
- Tailored to provide guidance on specific F-Tags or Tag dimensions;
- Defensible and practical to implement within the context of geriatric care;
- Conducive to greater consistency in surveyor judgments;
- Consistent with the OBRA State Operations Manual and Guidance to Surveyors;
- Process oriented, consistent, appropriate and realistic in their promotion of acceptable outcomes (i.e., by allowing for the option of explaining why something should not be given) or disapproval of other practices (i.e., by proposing that something should not be done or should be done differently); they should not just promote a laundry list of interventions or assessments without recognizing the

context of the care;
- Able to be documented by providers without major increases in paperwork;
- Widely disseminated to both providers and surveyors so that they can be mutually understood before a survey starts;
- Reflected in practical tools which can be used by providers to document compliance and by surveyors in the assessment of compliance and the application of key definitions;
- Supported by active joint training, guidance and monitoring from the state agency
- Reviewed on a periodic basis to assure that they reflect current practice and are being applied consistently and reasonably.

XI. Department Implementation

The Workgroup recognized that the clarification of the terms "avoidable," "unavoidable," "harm," "potential harm" and "immediate jeopardy," as they are applied in practice, will involve a process which must be implemented methodically and on a topic by topic basis. The Workgroup also recognized that similar work is underway by HCFA at this time. The Department, in accordance with the recommendations of the Workgroup, will proceed as follows:

1. As an initial step, the Department has identified two clinical care issues of concern in the OBRA program for which national clinical practice guidelines exist. These care issues are Fall Prevention and Medication Prescribing and Usage. These are significant issues because they are frequently cited in the survey process and because clinicians view them as significant concerns in the care of residents in nursing homes.

2. On April 24, 2001 the Department held a joint provider/surveyor training conference on the use of clinical practice guidelines and process measures for Fall Prevention and Medication Prescribing and Usage. The training related the clinical practice guidelines to OBRA requirements and stressed the need for providers to document process steps and for surveyors to consider them in evaluating medication and fall issues.

3. The Department will continue the Clarification Workgroup and will seek the advice of a clinical advisory panel in the development of new provider and surveyor tools that adapt the clinical practice guidelines on Fall Prevention and Medication Prescribing and Usage to facility practices--including suggested forms for documentation where appropriate. The advisory panel will meet in June of 2001. The resulting documents and forms may be piloted in selected nursing homes.

4. Surveyors will be trained in the summer of 2001 on how to use the factor tools and how to consider nursing home documentation of adherence to the accepted clinical practice guidelines in determining whether a specific negative outcome related to medications or falls outcome is "avoidable," "unavoidable," "harm," "potential harm" or "immediate jeopardy".

5. The tools and forms developed for the survey process will also be shared with providers in advance of their implementation in the field to provide an opportunity

for provider training and advance notice of issues that will be considered in the application of the terms “avoidable,” “unavoidable,” “harm,” “potential harm” and “immediate jeopardy” with respect to medications and falls. Implementation of the new tools and considerations is anticipated in the fall of 2001.

6. Once the tools and forms are implemented in the field, the advisory panel will be asked to serve as a validation/steering committee to monitor and advise the Department on the implementation of the program.

7. In the summer of 2001, additional clinical practice issues will be identified for presentation at the Fall 2001 joint provider/surveyor training. These may include pressure sores, hydration, pain management, other topics, or issues addressed by HCFA’s clarification efforts. Tools and training for these additional subjects will be developed in the fall of 2001 for implementation in the early winter of 2001, using the same process as was used for falls and medications, and modified if necessary based upon experience.

8. The Department will establish a system for evaluating the impact of the process on 1) consistency in the application of the terms “avoidable,” “unavoidable,” “harm,” “potential harm” and “immediate jeopardy”; 2) overall improvement of the survey process; and 3) improved care and prevention of recurring care problems.

APPENDIX A

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2000-2001

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APPENDIX B

The American Medical Directors Association (AMDA) guidelines include:

- **Depression (1996)**
- **Heart Failure (1996)**
- **Urinary Incontinence (1996)**
- **Pressure Ulcers (1996) and Pressure Ulcer Therapy (1999)**
- **Altered Mental States (1998)**
- **Dementia (1998)**
- **Osteoporosis (1998)**
- **Depression and Depression Pharmacotherapy Companion (1998)**
- **Falls and Fall Risks (1998)**
- **Chronic Pain Management In The Long Term Care Setting (1999)**